



Health Coverage & Help Paying Costs Application for One Person

Use this application to see what insurance choices you qualify for	 Free or low-cost insurance from Medicaid or the Kentucky Children's Health Insurance Program (KCHIP) Payment Assistance that can help you pay for your health coverage Affordable health insurance plans that offer comprehensive coverage to help you stay well 	
Who is this application for?	 Single individuals who: Live in Kentucky and plan to stay in Kentucky Do not have any dependents and cannot be claimed as a dependent on someone else's tax return 	
Apply faster online	Apply faster online at www.kynect.ky.gov.	
What you may need to apply	 Your social security number (or document number if you are a legal immigrant) Employer and income information (for example, paystubs, W-2 forms, or wage and tax statements) 	
Why do we ask for this information?	We ask about your Social Security Number (SSN) , your income and other information to see if you qualify for and if you can get any help paying for your health coverage costs.	
	If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.	
	We'll keep all the information you give us private, as required by law.	
What happens next?	Mail or fax your completed, signed application to: Office of the Kentucky Health Benefit Exchange 12 Mill Creek Park Frankfort, KY 40601 Fax: 1-502-573-2005	
	 If you don't have all the information we ask for, submit your application anyway. We will contact you for the missing information if we cannot complete the determination based on the information you give us. If we can make a determination, we will send you detailed information about the steps you will need to follow to select a plan. You will need to go online, call us, or get assistance from an insurance agent or kynector to enroll in a plan. 	
To get help	 Online: www.kynect.ky.gov By phone: Call Customer Service at 1-855- 4kynect (459-6328) In person: Find a list of places near where you live by visiting our website or calling us. En Español: Llame a nuestro Servicio al Cliente gratis al 1-855- 4kynect (459-6328) For TTY services call 1-855-326-4654 	



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STEP 1

Tell Us about Yourself

If someone else is helping you fill out this application, use **Appendix B** to give us that person's information.)

1. First Name, Middle initial, Las	st name, Suffix (as it appe	ears on your Social Security	card)		
, , ,		We need your SSN if you want coverage and have a SSN. We use SSNs to check income and other information to see if you are eligible for help with health coverage costs.			
3. If you want coverage and SS	SN is not provided, select	reason for not providing it.			
☐ Religious Objection☐ Does not have an SSN and		ceive SSN due to alien statu SSN for a valid non-work rea		ed for SSN se to provide SSN	
4. Date of Birth (mm/dd/yyyy) 5. Gender ☐ Male ☐ Female		6. Used tobacco at least 4 times a week in the past 6 months? ☐ Yes ☐ No			
7. Do you live in Kentucky and p	olan to stay in Kentucky?	□Yes □ No			
8. Home Address - ☐ Check her	e if you do not have a Hon	ne Address. You will still ha	ve to enter a Maili	ng Address below.	
9. City		10. State	11. Zip Code	12. County	
13. Mailing Address (Only requi	red if different from home	address)			
14. City		15. State	16. Zip Code	17. County	
18. Primary Phone Number ()	□ Home □ Work □ C	tell 19. Secondary Phone I	Number Hor	ne 🗆 Work 🗆 Cell	
20. ☐ Check here to allow kynect to send text message alerts to your primary phone number.		21. ☐ Check here to allow kynect to send text message alerts to your secondary phone number.			
22. Preferred Spoken Language	e (if not English)	23. Preferred Written L	anguage (if not E	nglish)	
24. Have you had a pregnancy pregnant? ☐ Yes. If yes, a. What is the due date or the b. How many children are/we c. Would you like to be referr	answer questions a–c. e last date of pregnancy? re expected with this preg	□No (mm/dd/yyyy) gnancy?			
25. Are you offered health cove ☐ Yes. If yes , you will need		-	• • •	No	
26. Do you want help paying for If yes , which month(s)?	medical bills from the las	t 3 months? ☐Yes ☐ N	No		



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	a federal income tax retu alth insurance even if you d			
□YES. If yes, answ	wer questions a & b.	□NO. If no, g	o to question b.	
If No, stop using One Person to b. Are you claimed	d as a dependent on son	lealth Coverage ents (even if you neone else's tax	do not want to apply for return? □Yes □ N	health coverage for them.)
	son does not want cover		everage mar are person	ordining you on their tax rotain
28. Are you a U.S. citizen or national? ☐ Yes ☐ No	☐ Yes . Answer qualified a. Immigration Dobument ID Noc. Have you lived	estions a–d belo ocument Type: _ lumber: in the U.S. since		No
30. Are you of Hispanic,	Latino or Spanish origin	? (OPTIONAL)	□Yes □No	
31. Race (OPTIONAL)				
☐ White☐ Black or AfricanAmerican☐ Chinese	☐ American Indian☐ Alaska Native☐ Asian Indian	☐ Filipino ☐ Japanese ☐ Korean	☐ Vietnamese☐ Other Asian☐ Native Hawaiian	☐ Guamanian or Chamorro☐ Samoan☐ Other Pacific Islander
or other group? \(\text{\text{\$\}\$}}}\$}}}}}}}} \endotinesetitiles }\end{times}} } \end{times}} } \end{times}}} \end{tines}} } \end{tines}}} \end{times}}} \end{times}}} \end{times}}} \end{times}}} \e	Yes. If yes , answer quest of the tribe?tribe primarily located in a receive or have you ever	er received a serv	□No vice from the Indian Heal	zed tribe, band, nation, community Ith Service, a tribal health ograms? Yes No
•	prison or jail or have you	been released i	n the past three months?	?
b. When did you lea	er questions a–c. er prison? (mm/dd/yyyy) ve prison? (mm/dd/yyyy) waiting for a decision on			
36. Do you need help w ☐ Yes ☐ No	ith activities of daily living	g (like bathing, d	ressing, etc.) or live in a	medical facility or nursing home?
37. Are you blind or peri	manently disabled?	□ Yes □ No		
38. Were you receiving If yes, in what state	Medicaid when you beca were you living?	ame too old to be		lacement?
39. If you are filling out to of death:	his application on behalf	of a person who	recently passed away, e	enter the deceased person's date



STEP 2 Current Job and Income Information

Use additional sheets of paper if you need to add more than two jobs.

Income from Job 1 1. Employ	Job 1 1. Employer Name Check here if income is from self-employment			
2. What is the gross amount you make (before taxes)?		3. How often?	☐ Weekly☐ Every two weeks	☐ Twice a month☐ Monthly
Income from Job 2 4. Employ	ver Name	☐ Che	ck here if income is from	m self-employment
5. What is the gross amount you make (before taxes)?		6. How often?	☐ Weekly☐ Every two weeks	☐ Twice a month☐ Monthly
7. Additional Income: List here any additional income you may receive, give the amount and how often you get it. Do not include income from child support, Supplemental Security Income (SSI), veteran's income, or Worker's Compensation. If none, leave blank.				
Type of Income	How Much?		How Often?	
☐ Social Security	\$	□Weekly	☐Twice a month	□Monthly
☐ Pensions	\$	□Weekly	☐Twice a month	□Monthly
☐ Interest or Dividend	\$	□Weekly	☐Twice a month	□Monthly
☐ Disability Payments	\$	□Weekly	☐Twice a month	□Monthly
☐ Unemployment	\$	□Weekly	☐Twice a month	□Monthly
□ Other —	. \$	□Weekly	☐Twice a month	□Monthly
8. Household Deductions: Give us information about things that you pay and that can be deducted on an income tax return. Giving us this information could make the cost of health insurance lower.				
Type of Deduction	How Much?		How Often?	
☐ Alimony Paid	\$	□Weekly	☐Twice a month	□Monthly
☐ Student Loan Interest	\$	□Weekly	☐Twice a month	□Monthly
☐ Educator Expenses	\$	□Weekly	☐Twice a month	□Monthly
☐ School Tuition and Fees	\$	□Weekly	☐Twice a month	□Monthly
 Yearly Income: What is your bonuses, seasonal income, et 		for the covera	age year (including ar	ny monthly changes,



STEP 3 Other Healthcare Coverage

Do you have health coverage now, including denta KCHIP?	al and major medical coverage that is not Medicaid or		
☐ YES. If yes , complete the information below.	□ NO.Policy Number —Coverage start date —Coverage end date —		
Name of policy holder ————————————————————————————————————			
Name of insurance company			
Insurance Company's Address			
STEP 4 Sign and Date this			
this form to the best of my knowledge and belief. I knowledge and the land that I must tell kynect if anything changes from can visit kynect.ky.gov or call 1-855-4kynect (459-60). If I think kynect has made a mistake, I can appeal its of the action is wrong, and ask for a fair review of the action is wrong, and ask for a fair review of the action of the land that under federal law, discrimination is not per sexual orientation, gender identity, or disability. I can www.hhs.gov/ocr/office/file.	decision. To appeal means to tell someone at kynect that I think ction. I know that I can be represented in the process by apportant information will be explained to me. The mitted on the basis of race, color, national origin, sex, age,		
	Security, and/or any other trusted source. If the information does		
	ect one) rs 2 years 1 year		
	registered where I currently live, I can choose to register to vote oter registration application in the mail. Checking yes or no below on will be mailed to me. No, I don't want to register to vote.		
go to Medicaid to reimburse it for the expense.	nse, any other health insurance or legal settlement payments will		
 I understand that my application may be reviewed to n application is reviewed, I must cooperate with the rev 	nake sure that eligibility was determined correctly. If my iew.		
Signature	Date (mm/dd/yyyy)		



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